Headquarters U.S. Air Force

Integrity - Service - Excellence

PCE MEPRS and CHCS File and Table Guidance

Final Version

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Guidance

- **PCO Personnel shall be assigned to one PCE MEPR**
- **PCMs should not float outside their PCE**
- **PCO personnel are to be in one PCE MEPR**
  - **Allows freedom to float personnel *within* the PCE**
  - **Support personnel may be used in more than one PCE on a temporary basis, when necessary**
- **Non-PCMs and non-PCO personnel are able to work (or be CHCS assigned) in more than one PCE**
  - **e.g. SGH, PA or nurse provider (LIP) whose primary duty is not direct patient care**

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PCE Designations

- **Primary Care, Family Practice, Pediatrics, and Internal Medicine will retain their specific modifiers (BG##, BH##, BD##, BA##)**

- **The 4th level will be reserved for PCE**
  - **BGA#, BDA#, BAA#, BHA#**
  - **PCE: A, B, C, D, E, F, H, I, J**
    - **BGAA, BGAB, BGAC etc.**
  - **BGAG will remain reserved for readiness**
  - **BGAS will be reserved for specialty type clinics**
    - **e.g. dysplasia clinic with an FP, vasectomy clinic, etc.**
  - **BGA5 will remain surgical in nature**

- **BGAS/BGA5 will keep procedures or "specialty" care within the PCE MEPRS (or BDAS, BAAS, etc.)**

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Consequences, Real or Potential

- **Patients booked outside of their empanelled PCE**
  - **Will require an internal CHCS MCP referral booking**
  - **This will encourage booking within their PCE**

- **Increased requirement to keep CHCS files/tables up to date**
  - **Staff movement between PCEs requires CHCS file & table builder(s) and Flight/Element leadership coordination**
  - **PCE MEPRS/SADR productivity data dependent on accurate files and tables**
  - **Recommend at least a quarterly review/verification**

- **Some MTFs will have a large “upfront” files/tables cleanup**
  - **MTFs with T-Nex (T-45 days) need prompt attention**
  - **Other MTFs will have more time to execute**

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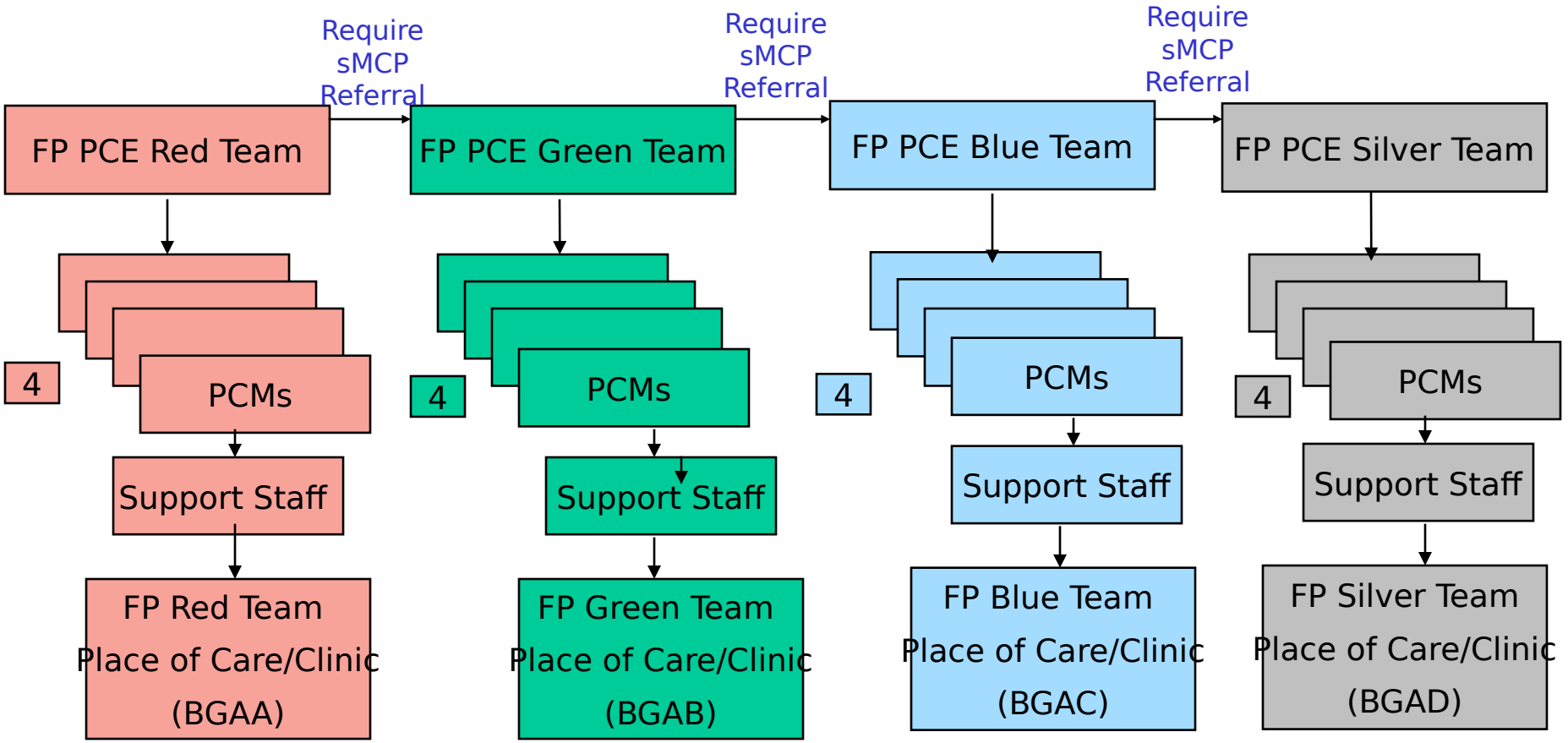
Floaters and PCE Vision

- **"Floater" definition and use will continue to be an area of discussion and clarification. General guidelines:**
  - **Floating within PCE: Expected; is the essence of cross coverage!**
  - **Floating across PCE's:**
    - **PCM AFSC "Part Timers": SGH, Sq/CC, etc, makes sense**
    - **Full Time Cross-PCE floaters discouraged -- PCE's should be robust enough for cross-coverage to occur within the PCE's**
    - **Support Staff: work in progress -- in general if they don't have appointment schedules, they can work in any PCE for MEPRS accounting. Workload captured on time sheets.**
- **PCE "crew integrity" IS SG VISION!!!!**

Primary Care Element File and Table Design

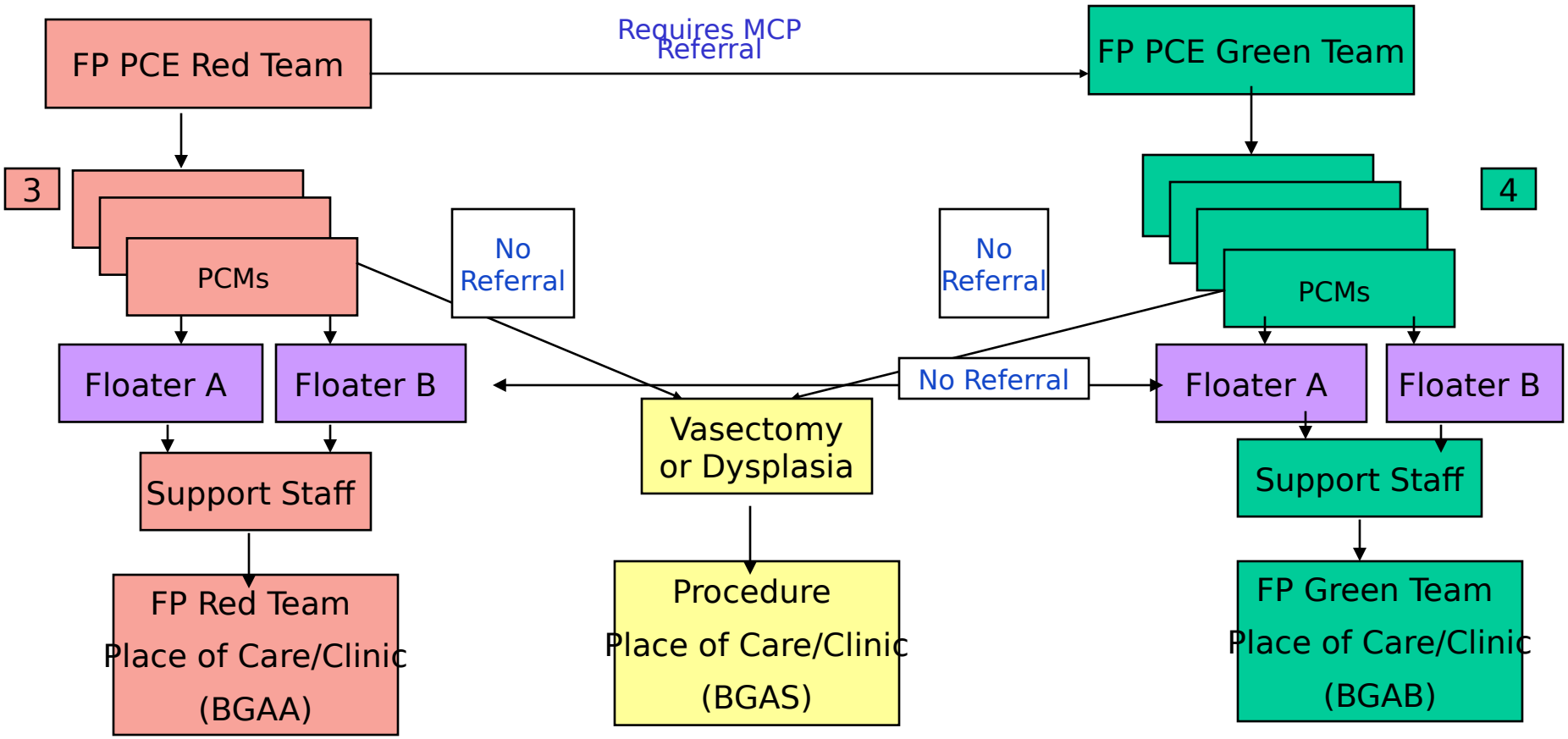
Single Family Practice Physical Clinic
16 PCMs, 64 Support Staff, and No Floaters



** Support personnel may be used in more than one PCE on a temporary basis when necessary.

Primary Care Element File and Table Design

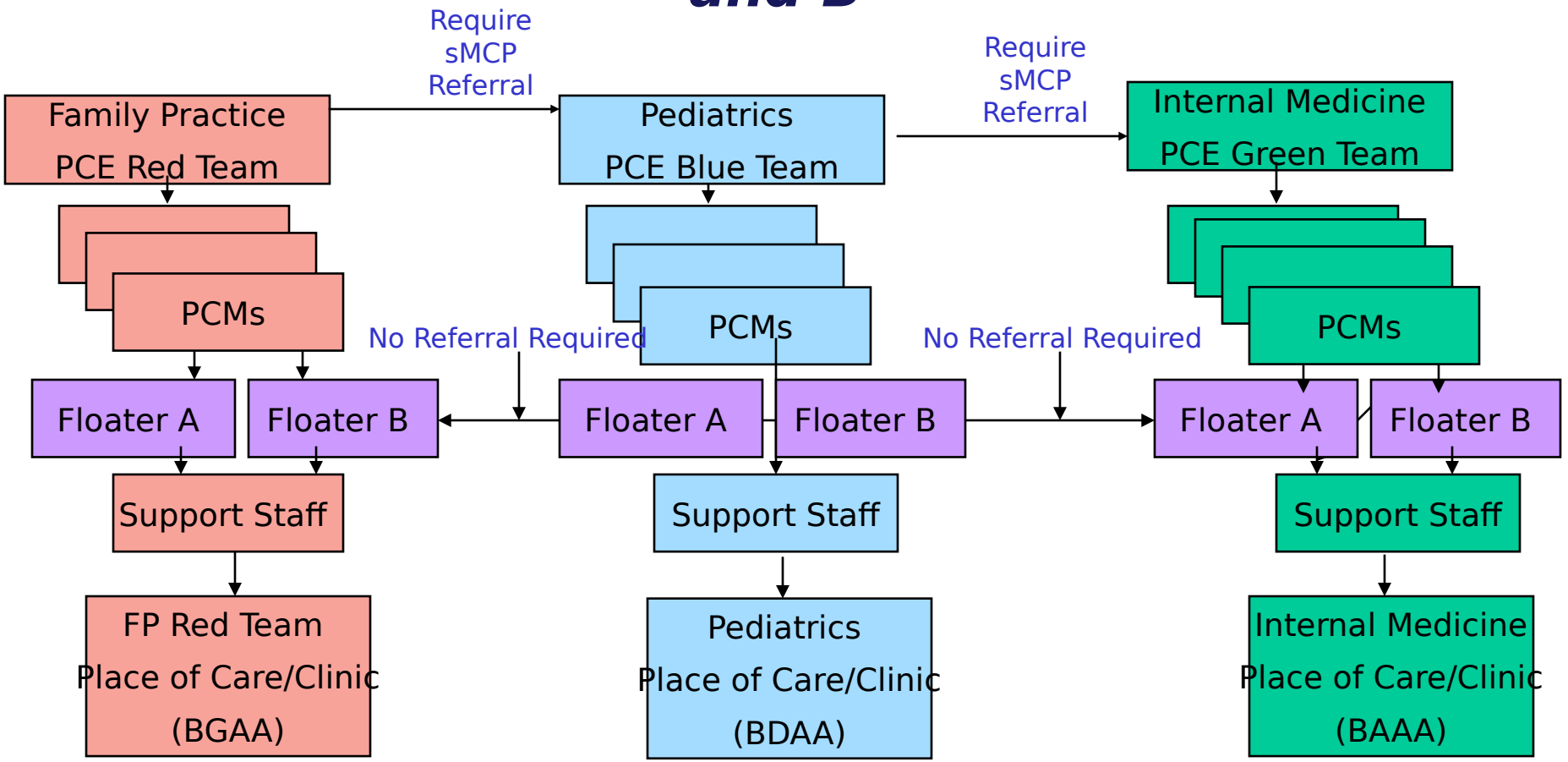
Single Family Practice Physical Clinic
7 PCMs, 2 Floaters (not PCMs)



Specialty Providers such as Mental Health (BHOP) or Women's Health will be booked to their Clinic Specialty and may be a PCE group member

Primary Care Element File and Table Design

Family Practice, Pediatrics, and Internal Medicine Separate Clinics with Floaters A and B



Questions???

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Backup Slides/Questions

- GME?
  - Attempt to set up PCEs (not required as of now)
    - 1 staff with one resident in each year (FP-GME Pod)
    - 3-5 FP-GME Pods per PCE
  - Floating between PCEs may be necessary, not goal

- Is it better to have fewer or more PCMs in a PCE?
  - MTF option.
  - Larger PCEs will help stability during summer change
  - Personally, if I had 9 PCMs, I would go 4-5 vs. 3-3-3
  - MTF option (repeated for emphasis)
- POCs to be determined (How many?)
  - MEPRS, Policy, File and Table Builds, Others?